



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  J.T. DILGER JR., MD 6718 MONTAY BAY DRIVE SPRING, TX 77389	MFDR Tracking #: M4-09-A135-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  SERVICE LLOYDS INSURANCE CO Box #: 42	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

The Requestor did not submit a position statement.

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill(s) (One bill)
3. EOB(s) (One EOB)
4. Medical Records
5. Total Amount Sought - \$425.00

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "Harris & Harris represents Service Lloyds Insurance Company (hereinafter Respondent), and files this response to the Medical Dispute filed by Requestor, Dr. J. Thomas Dilger, M.D., in the above-identified matter. An MDR response was received on December 8, 2009. Therefore, this Response is submitted timely. The Requestor is seeking reimbursement from the Carrier for date of service August 11, 2008 in the amount of \$425 for a Designated Doctor's Examination. If this is not the correct dispute, then please contact the undersigned so that the Respondent and the undersigned may prepare a proper response. Respondent reserves the right to add or supplement this response with additional information, if necessary. At the outset, it should be noted that the request for an additional \$150 on CPT Code 99456-W8, has been paid as indicated on the attached EOB. This amount was paid on July 6, 2009. Next, the request for an {sic} \$150.00 for an "additional body area" is unfounded because there was no additional body area included in the IR measurements. As shown on the MMI report submitted by the provider, IR measurements were conducted only on a finger. Therefore, no additional reimbursement is warranted on this CPT Code. Finally, the \$125.00 requested for CPT 96118 is not supported by the documentation submitted. The description of this Code per Ingenix is: Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. The only documentation submitted was a questionnaire that the claimant filled out. This is not the equivalent of psychological testing. The provider has not submitted any documentation to support this procedure code. Therefore, no additional reimbursement for this Code is warranted."

**Principal Documentation:**

1. Response Package
2. Reconsideration EOB
3. Cashed check verification information

**PART IV: SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8/11/08	99456-W5	N/A	\$150.00	\$0.00
8/11/08	99456-W8	N/A	\$150.00	\$0.00
8/11/08	96118	N/A	\$125.00	\$0.00
<b>Total Due:</b>				<b>\$0.00</b>

**PART V: FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 28 Tex. Admin. Code §134.204 sets out the medical guidelines for workers' compensation specific services provided on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 2/18/09

- 145 – Please resubmit with appropriate fee schedule code
- 151 – Payment adjusted/undocumented services
- W1 – Workers' Compensation State Fee Schedule Adj
- 150 – Payment adjusted/unsupported service level
- 16 – Not all info needed for adjudication was supplied

Explanation of benefits dated 7/6/09 (submitted by the Respondent)

- ORC – See Additional Information
- W3 – Additional payment on appeal/reconsideration
- W1 – Workers' Compensation State Fee Schedule Adj

**Issues**

- Did the Requestor file the dispute in accordance with rule §133.307?
- Did the Requestor receive payment for the services in dispute?
- Does the medical documentation that the Requestor provided support the services billed under CPT code 99456-W5?
- What is the description of CPT code 96118 and does the medical documentation that the Requestor provided document the services billed under CPT code 96118?
- Is the Requestor entitled to reimbursement?

**Findings**

- Pursuant to rule §133.307(c)(2)(A)(F), provider requests for medical dispute resolution (MDR) shall include: a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills) and a position statement of the disputed issue(s) that shall include: a description of the health care for which payment is in dispute, the requestor's reasoning for why the disputed fees should be paid or refunded, how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues, and how the submitted documentation supports the Requestor position for each disputed fee issue. The Requestor submitted only one bill that is not on a DWC approved paper billing format. The Requestor did not submit a position statement. Therefore, this dispute was not filed in accordance with Rule §133.307.
- The Requestor listed CPT code 99456-W8 (ability of the employee to return to work) as one of the disputed services on the DWC-60 table of disputed services with a total amount billed of \$500.00 and a partial amount paid of \$350.00 leaving the amount of \$150.00 in dispute. The Division received this dispute on 7/8/09. The Respondent submitted a response to this dispute received by the Division on 12/17/09 stating that an additional amount of \$150.00 was paid on CPT code 99456-W8 on 7/6/09 and submitted a supporting EOB. The Requestor was contacted by the Division by fax transmission on 6/28/10 asking to confirm if this dispute was being pursued or if it had been paid and no longer pursuing with a note that if partial payment received to submit an updated table showing the services still in dispute. The Division received a reply from the Requestor on 7/8/10 indicating that the dispute is not paid. The Respondent

has submitted documentation verifying that check number 8095446 was issued on 7/13/09 to the Requestor for \$150.00 and that this check cleared on 7/30/09. Therefore, the disputed service for CPT code 99456-W8 has been paid and is no longer in dispute.

3. The Requestor listed CPT code 99456-W5 (designated doctor) on the DWC-60 table of disputed services with the amount of \$150.00 in dispute. This disputed service has not been paid. Pursuant to rule §134.204(j)(3)(C), Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: for billing and reimbursement of an MMI evaluation, an examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350. Pursuant to rule §134.204(j)(4)(C), the following applies for billing and reimbursement of an IR evaluation. For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. Musculoskeletal body areas are defined as follows: spine and pelvis; upper extremities and hands; and, lower extremities (including feet). The MAR for musculoskeletal body areas shall be as follows: If full physical evaluation, with range of motion, is performed: \$300 for the first musculoskeletal body area; and \$150 for each additional musculoskeletal body area. The documentation submitted by the Requestor supports that only the upper extremity musculoskeletal body area was evaluated. The Requestor billed CPT 99456-W5 (designated doctor) x 3 with amounts of \$350.00, \$300.00 and \$150.00. Per the submitted EOB, the carrier paid the charged amounts of \$350.00 and \$300.00. These paid charges reflect \$350.00 for the maximum medical improvement examination and \$300.00 for the upper extremity impairment rating. There is no documentation to support that a second musculoskeletal body area was examined. Therefore reimbursement for an additional \$150.00 is not recommended.
4. The Requestor also listed CPT code 96118 on the DWC-60 table of disputed services in the amount of \$125.00. CPT 96118 is described as follows: Neuropsychological testing (eg, Halstead-Ritan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. The documentation submitted by the Requestor does not meet the documentation requirements for billing CPT code 96118. Therefore, reimbursement for this disputed service is not recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services involved in this dispute.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

7/20/10

\_\_\_\_\_  
Date

### **PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**